



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEVEN HAMMERMAN
7401 S MAIN STREET
HOUSTON TX 77030-4509

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-10-5116

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The main surgeon was paid and carrier didn't deny that claim as of network when both providers are with Fondren and share the same tax ID #."

Amount in Dispute: \$278.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance, Division of Workers' Compensation Acts and Rules. The billed charges for date of service 12/14/09 are denied as Dr Hammerman does not participate in the Liberty Health Care Network (HCN)."

Response Submitted by: Kathy McDaniel, Liberty Mutual, P. O. Box 3423, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2009	63030-80	\$278.74	\$-0-

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out MDR in general.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 18, 2010 and June 14, 2010

- 38 (X397) – Provider is not within the Liberty Health Care Network (HCN) for this customer. TX Insurance Code 1305.004 (B) and labor Code 401.011. (X397)

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on August 06, 2010 for resolution pursuant to 28 Texas Administrative Code §133.307.
2. 28 Texas Administrative Code §133.305 (a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a)(6) of the same rule as "Health care **not** [emphasis added] delivered, or arranged by a certified worker's compensation health care network as defined in Insurance Code chapter 1305 and related rules..." 20 Texas Administrative Code §133.307 (a)(1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out of network health care..." therefore, pursuant to 28 Texas Administrative Code §§133.305 and 133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.
3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled *Insurance Carrier Liability for Out-of-Network Care*. As indicated by their position statements, the Requestor and the Respondent agree this is a Health Care Network claim. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is \$0.00.

ORDER

Based upon the reasons stated above, the Division concludes that medical fee dispute is not the appropriate venue for resolution of the issues raised by requestor. As a result, the amount ordered is \$0.00.

Authorized Signature

_____	Pat DeVries	October 10, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

